

Notice of Independent Review Decision

**[Date notice sent to all parties]:** July 2, 2012

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Right Shoulder Scope w/ BIC TEN/ sub decompression/ DCR/ poss RCR 29828-29826-29824-29827 to be complete by 8-15-12

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**

The physician performing this review is Board Certified, American Board of Orthopedic Surgery. He has been in practice since 1998 and is licensed in Texas, Oklahoma, Minnesota and South Dakota.

**REVIEW OUTCOME:**

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

- |   |                                  |
|---|----------------------------------|
| <input checked="" type="checkbox"/> Upheld    | (Agree)                          |
| <input type="checkbox"/> Overturned           | (Disagree)                       |
| <input type="checkbox"/> Partially Overturned | (Agree in part/Disagree in part) |

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

Upon independent review, the reviewer finds the previous adverse determinations should be upheld.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

Records Received: 22 page fax 06/20/12 Texas Department of Insurance IRO request, 168 pages of documents received via fax on 06/20/12 URA response to disputed services including administrative and medical. Dates of documents range from 01/21/12 to 06/20/12

**PATIENT CLINICAL HISTORY [SUMMARY]:**

Xx is a female injured xx/xx/xx at her worksite. She was reportedly working as an using a metal staple remover to remove staples from thick insurance policy files. She reportedly felt a pop and a sharp pain in her right shoulder. Since that time, her medical records would indicate she has had physical therapy treatments,

chiropractic treatments, as well as subacromial injections into the affected shoulder, none of which has given her significant relief of her symptoms.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:**

The request for IRO dated 06/19/12 and signed by the treating physician, M.D., requests the above-described procedures. Though there is clinical evidence of impingement syndrome along with labral pathology, there is no imaging evidence in the medical records for rotator cuff tear. The MRI is also inclusive of findings for labral tear. However, this is not a portion of the requested procedure in the request for consideration mentioned previously dated 06/19/12. Of note, there is in the record set an "Appeal Surgery Request" form on letterhead from the Orthopedic Group, which requests right shoulder scope with labral repair, biceps tenodesis, subacromial decompression, distal clavicle resection, and possible rotator cuff repair. However, this was not part of the official request from the Texas Department of Insurance. As a consequence, this review is based upon that official request from the Texas Department of Insurance signed by Dr. as mentioned above.

The only MRI report available for review is dated 03/23/11 and specifically states no partial- or full-thickness rotator cuff tear is seen. The report of a more recent MRI study, however, is not available for review.

The patient has clearly suffered a work-related injury and does have pathology evident on the MRI. Specifically, there is evidence for a torn biceps/labral complex and labral tear. She has failed a lengthy period of appropriate nonoperative care, and surgical consideration should be appropriately given. However, the requested services do not appear to match with the imaging studies that are available to me for review, and as such, the requested services should be denied.

This report is based upon the medical records available to me. I have not had the opportunity to meet or examine the patient in question, nor have I had the opportunity to visualize analyze any imaging studies. Rather, this review is based on a report of those imaging studies made available to me.

Surgery for rotator cuff repair

Recommended as indicated below. Repair of the rotator cuff is indicated for significant tears that impair activities by causing weakness of arm elevation or rotation, particularly acutely in younger workers. However, rotator cuff tears are frequently partial-thickness or smaller full-thickness tears. For partial-thickness rotator cuff tears and small full-thickness tears presenting primarily as impingement, surgery is reserved for cases failing conservative therapy for three months. The preferred procedure is usually arthroscopic decompression, but the outcomes from open repair are as good or better. Surgery is not indicated for patients with mild symptoms or those who have no limitations of activities. ([Ejnisman-Cochrane, 2004](#)) ([Grant, 2004](#)) Lesions of the rotator cuff are best thought of as a continuum, from mild inflammation and degeneration to full avulsions. Studies of normal subjects document the universal presence

of degenerative changes and conditions, including full avulsions without symptoms. Conservative treatment has results similar to surgical treatment but without surgical risks. Studies evaluating results of conservative treatment of full-thickness rotator cuff tears have shown an 82-86% success rate for patients presenting within three months of injury. The efficacy of arthroscopic decompression for full-thickness tears depends on the size of the tear; one study reported satisfactory results in 90% of patients with small tears. A prior study by the same group reported satisfactory results in 86% of patients who underwent open repair for larger tears. Surgical outcomes are much better in younger patients with a rotator cuff tear, than in older patients, who may be suffering from degenerative changes in the rotator cuff. Referral for surgical consultation may be indicated for patients who have: Activity limitation for more than three months, plus existence of a surgical lesion; Failure of exercise programs to increase range of motion and strength of the musculature around the shoulder, plus existence of a surgical lesion; Clear clinical and imaging evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical repair; Red flag conditions (e.g., acute rotator cuff tear in a young worker, glenohumeral joint dislocation, etc.). Suspected acute tears of the rotator cuff in young workers may be surgically repaired acutely to restore function; in older workers, these tears are typically treated conservatively at first. Partial-thickness tears are treated the same as impingement syndrome regardless of MRI findings. Outpatient rotator cuff repair is a well accepted and cost effective procedure. ([Cordasco, 2000](#)) Difference between surgery & exercise was not significant. ([Brox, 1999](#)) There is significant variation in surgical decision-making and a lack of clinical agreement among orthopaedic surgeons about rotator cuff surgery. ([Dunn, 2005](#)) For rotator cuff pain with an intact tendon, a trial of 3 to 6 months of conservative therapy is reasonable before orthopaedic referral. Patients with small tears of the rotator cuff may be referred to an orthopaedist after 6 to 12 weeks of conservative treatment. ([Burbank2, 2008](#)) Patients with workers' compensation claims have worse outcomes after rotator cuff repair. ([Henn, 2008](#))

*Revision rotator cuff repair:* The results of revision rotator cuff repair are inferior to those of primary repair. While pain relief may be achieved in most patients, selection criteria should include patients with an intact deltoid origin, good-quality rotator cuff tissue, preoperative elevation above the horizontal, and only one prior procedure. ([Djurasic, 2001](#))

*Recent research:* Evidence on the pros and cons of various operative and nonoperative treatments for rotator cuff tears is limited and inconclusive, an AHRQ comparative effectiveness review concluded. While the data are sparse, patients improved substantially with all interventions; there were few clinically important differences between approaches, and complications were rare. Most patients try to resolve their pain and disability with a course of physical therapy before attempting surgery, but the study found very little good quality research to guide the choice of nonoperative treatment, the timing of treatment, and who would most benefit from various forms of treatment. Four out of five studies comparing surgical and nonsurgical management favored operative repair, but the evidence was too limited to make conclusions regarding comparative effectiveness. 113 studies comparing various operations found no differences in functional outcomes between open vs mini-open repair, mini-open vs arthroscopic repair, arthroscopic repairs with vs without acromioplasty, and single-row vs double-row fixation. Patients who had mini-open repair returned to work about a month earlier than patients who had open repair. On the other hand, functional improvement was better after open repair compared with arthroscopic debridement. With regard to adding continuous passive motion to postoperative physical therapy, 11 trials yielded moderate evidence for no difference in function or pain. One study found no difference in range of motion or strength, while another suggested that adding continuous passive motion shortened the time until return to work and the time to 90 degrees abduction. For other postoperative rehabilitation strategies, one study showed that progressive loading reduced pain compared to traditional loading. In general, though, most studies found no difference in health-related quality of life, function, pain, range of motion, and strength with one approach versus another (e.g., with or without aquatics, individualized vs at home alone, videotape vs therapist-based, etc.). In the 72 studies that assessed prognostic factors, older age, increasing tear size, and greater preoperative symptoms were consistently associated with recurrent tears, whereas gender, workers' compensation status, and duration of symptoms usually did not predict poorer outcomes. ([Seida, 2010](#)) "Rotator cuff surgery is a viable option for many patients, but, as with any surgery, it is not for everybody," said AHRQ Director Carolyn M. Clancy, M.D. "This report has good news: most interventions work, and each patient should talk

to his or her doctor about which to option to pursue." Most older patients who suffer a rotator cuff tear are first treated with up to 3 months of nonsurgical treatment such as pain and anti-inflammatory medications, exercise, and rest. If treatments other than surgery do not work, the rotator cuff may be repaired surgically, using a variety of methods ranging from minimally invasive techniques to an open operation. Patients can then undergo rehabilitation to restore their range of motion, muscle strength, and function following surgery. Rotator cuff tears also can occur in younger adults, usually as a result of traumatic injury. In such cases they are almost always treated with surgery. Some doctors have maintained that earlier surgery results in less pain and better use of the shoulder, leading to an earlier return to work and decreased costs; so, patients often face the difficult decision of opting for surgery rather than waiting for nonoperative treatments to work. However, researchers found little evidence that earlier surgery benefits patients. Comparative Effectiveness of Nonoperative and Operative Treatments for Rotator Cuff Tears is the newest comparative effectiveness report from the AHRQ's Effective Health Care Program. The Effective Health Care Program represents the leading federal effort to compare alternative treatments for health conditions and make the findings public, to help doctors, nurses, pharmacists and others work together with patients to choose the most effective treatments. ([Clancy, 2010](#)) This prospective cohort study concluded that PT is effective for most patients with atraumatic full-thickness rotator cuff tears and shoulder pain, without the need for surgery. At six weeks fewer than 10% of patients had decided to undergo surgery, and after 2 years, only 2% of the rest had opted for surgery. Patients did most of their physical therapy at home and usually made only 1 weekly visit to the physical therapist. ([Kuhn, 2011](#)) One-third of rotator cuff repairs fail, and 74% of the failures occur within three months of surgery. Healed tendons, or recurrent tears, at six months can predict outcomes at seven years. ([Kluger, 2011](#)) Not surprisingly, larger tears are harder to repair, and the retear rate based on rotator cuff tear size is: 10% for  $\leq 2$  cm<sup>2</sup>; 16% for 2–4 cm<sup>2</sup>; 31% for 4–6 cm<sup>2</sup>; 50% for 6–8 cm<sup>2</sup>; & 57% for  $>8$  cm<sup>2</sup>. ([Murrell, 2012](#)) There is insufficient evidence to suggest efficacy in operative or nonoperative treatment of rotator cuff tears in in patients aged older than 60 years. ([Downie, 2012](#))

## **ODG Indications for Surgery™ -- Rotator cuff repair:**

**Criteria** for rotator cuff repair with diagnosis of full thickness rotator cuff tear AND Cervical pathology and frozen shoulder syndrome have been ruled out:

**1. Subjective Clinical Findings:** Shoulder pain and inability to elevate the arm; tenderness over the greater tuberosity is common in acute cases. PLUS

**2. Objective Clinical Findings:** Patient may have weakness with abduction testing. May also demonstrate atrophy of shoulder musculature. Usually has full passive range of motion. PLUS

**3. Imaging Clinical Findings:** Conventional x-rays, AP, and true lateral or axillary views. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of deficit in rotator cuff.

**Criteria** for rotator cuff repair OR anterior acromioplasty with diagnosis of partial thickness rotator cuff repair OR acromial impingement syndrome (80% of these patients will get better without surgery.)

**1. Conservative Care:** Recommend 3 to 6 months: Three months is adequate if treatment has been continuous, six months if treatment has been intermittent. Treatment must be directed toward gaining full ROM, which requires both stretching and strengthening to balance the musculature. PLUS

**2. Subjective Clinical Findings:** Pain with active arc motion 90 to 130 degrees. AND Pain at night (Tenderness over the greater tuberosity is common in acute cases.) PLUS

**3. Objective Clinical Findings:** Weak or absent abduction; may also demonstrate atrophy. AND Tenderness over rotator cuff or anterior acromial area. AND Positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test). PLUS

**4. Imaging Clinical Findings:** Conventional x-rays, AP, and true lateral or axillary view. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of deficit in rotator cuff.

([Washington, 2002](#))

For average hospital LOS if criteria are met, see [Hospital length of stay](#) (LOS).

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR  
OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- ☐ AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- ☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- ☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- ☐ INTERQUAL CRITERIA
- ☐ MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- ☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- ☐ MILLIMAN CARE GUIDELINES
- ☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- ☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- ☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- ☐ TEXAS TACADA GUIDELINES
- ☐ TMF SCREENING CRITERIA MANUAL
- ☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- ☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)